

Transformation Accountability (TRAC)
Center for Mental Health Services

**NOMs Client-Level Measures for Discretionary
Programs Providing Direct Services**

SERVICES TOOL
for
Minority AIDs Initiative – TCE, Adult Programs
REASSESSMENT INTERVIEW



March 2013
Version 6

Public reporting burden for this collection of information is estimated to average 30 minutes per response if all items are asked of a consumer/participant; to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0285.

RECORD MANAGEMENT

[RECORD MANAGEMENT IS REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND DISCHARGE REGARDLESS OF WHETHER AN INTERVIEW IS CONDUCTED.]

Consumer ID |_|_|_|_|_|_|_|_|_|_|

Grant ID (Grant/Contract/Cooperative Agreement) |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Site ID _____

1. Indicate Assessment Type:

- Reassessment

Which 6-month reassessment?

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[ENTER 06 FOR A 6-MONTH, 12 FOR A 12-MONTH, 18 FOR AN 18-MONTH ASSESSMENT, ETC.]

2. Was the interview conducted?

☐ Yes

When?

| | / | | / | | | |
 MONTH DAY YEAR

B. FUNCTIONING**1. How would you rate your overall health right now?**

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ REFUSED
- ☐ DON'T KNOW

2. In order to provide the best possible mental health and related services, we need to know what you think about how well you were able to deal with your everyday life during the past 30 days. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. I deal effectively with daily problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. I am able to control my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. I am able to deal with crisis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. I am getting along with my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I do well in social situations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
f. I do well in school and/or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. My housing situation is satisfactory.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
h. My symptoms are not bothering me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. FUNCTIONING (Continued)

3. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
During the past 30 days, about how often did you feel ...	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	REFUSED	DON'T KNOW
a. nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. so depressed that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. FUNCTIONING (Continued)

Questions B4c-t, B4A
OMB No. 0930-0208
Expiration Date 05/31/2015

4. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

[READ EACH QUESTION TO THE CONSUMER. IF THE # OF DAYS IS GREATER THAN 0 ASK THE ROUTE OF ADMINISTRATION. NOTE THE USUAL ROUTE. IF MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).]

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

[IF THE VALUE IN ANY ITEM B4g THROUGH B4t > 0, THEN THE VALUE IN B4e MUST BE > 0.]

QUESTION	RESPONSE OPTIONS					
	# of Days	REFUSED	DON'T KNOW	Route	REFUSED	DON'T KNOW
During the past 30 days, how many days have you used...						
a) Tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	___	<input type="radio"/>	<input type="radio"/>			
b) Alcoholic beverages (beer, wine, liquor, etc.)? <i>[IF b=0, RF, DK, THEN SKIP TO ITEM e.]</i>	___	<input type="radio"/>	<input type="radio"/>			
c) Alcohol to intoxication (5+ drinks in one sitting)?	___	<input type="radio"/>	<input type="radio"/>			
d) Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)?	___	<input type="radio"/>	<input type="radio"/>			
e) Illegal drugs?	___	<input type="radio"/>	<input type="radio"/>			
<i>[IF b or e =0, RF, DK, THEN SKIP TO ITEM g.]</i> f) Both alcohol and drugs (on the same day)?	___	<input type="radio"/>	<input type="radio"/>			
g) Cannabis (marijuana, pot, grass, hash, joints, blunts, chronic, weed, Mary Jane, etc.)?	___	<input type="radio"/>	<input type="radio"/>	___	<input type="radio"/>	<input type="radio"/>
h) Cocaine (coke, crack, etc.)?	___	<input type="radio"/>	<input type="radio"/>	___	<input type="radio"/>	<input type="radio"/>
i) Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	___	<input type="radio"/>	<input type="radio"/>	___	<input type="radio"/>	<input type="radio"/>
j) Methamphetamine or other amphetamines (crystal meth, uppers, speed, ice, chalk, glass, fire, crank, etc.)?	___	<input type="radio"/>	<input type="radio"/>	___	<input type="radio"/>	<input type="radio"/>
k) Inhalants (nitrous oxide, glue, gas, paint thinner, poppers, snappers, rush, whippets, etc.)?	___	<input type="radio"/>	<input type="radio"/>	___	<input type="radio"/>	<input type="radio"/>

B. FUNCTIONING (Continued)

During the past 30 days, how many days have you used...	# of Days	REFUSED	DON'T KNOW	Route	REFUSED	DON'T KNOW
l) Benzodiazepines, sedatives or sleeping pills (Serepax, Ativan, Librium, Rohypnol, GHB, etc.) Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estazolam (Prosom and Rohypnol—also known as roofies, roche, and cope)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
m) Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
n) Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
o) Ketamine (known as Special K or Vitamin K)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
p) Other tranquilizers, downers, sedatives or hypnotics?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
q) Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
r) Street opiates – heroin (Smack, H, Junk, Skag, opium etc.)?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
s) Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, morphine, Diluadid, Demerol, Darvon, codeine, Tylenol 2, 3, 4, etc.) or non-prescription methadone?		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
t) Other illegal drugs – specify: _____		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

[IF ANY ROUTE OF ADMINISTRATION IN B4g – B4t = 4 or 5, THEN CONTINUE TO B4A; OTHERWISE SKIP TO GAF SCORE.]

4A. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

- ☐ Always
- ☐ More than half the time
- ☐ Half the time
- ☐ Less than half the time
- ☐ Never
- ☐ REFUSED
- ☐ DON'T KNOW

B. FUNCTIONING (Continued)

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

DATE GAF WAS ADMINISTERED:

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 /

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 /

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 MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? GAF =

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B. VIOLENCE AND TRAUMA

9. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- ☐ Never
- ☐ Once
- ☐ A few times
- ☐ More than a few times
- ☐ REFUSED
- ☐ DON'T KNOW

C. STABILITY IN HOUSING

1.	In the past 30 days how many ...	Number of Nights/ Times	REFUSED	DON'T KNOW
a.	nights have you been homeless?	_ _ _	<input type="radio"/>	<input type="radio"/>
b.	nights have you spent in a hospital for mental health care?	_ _ _	<input type="radio"/>	<input type="radio"/>
c.	nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	_ _ _	<input type="radio"/>	<input type="radio"/>
d.	nights have you spent in correctional facility including jail, or prison?	_ _ _	<input type="radio"/>	<input type="radio"/>
<i>[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS).]</i>		_ _ _		
e.	times have you gone to an emergency room for a psychiatric or emotional problem?	_ _ _	<input type="radio"/>	<input type="radio"/>

[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]

2. In the past 30 days, where have you been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO THE CONSUMER. SELECT ONLY ONE.]

- ☐ OWNED OR RENTED HOUSE, APARTMENT, TRAILER, ROOM
- ☐ SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, ROOM
- ☐ HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- ☐ GROUP HOME
- ☐ ADULT FOSTER CARE
- ☐ TRANSITIONAL LIVING FACILITY
- ☐ HOSPITAL (MEDICAL)
- ☐ HOSPITAL (PSYCHIATRIC)
- ☐ DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- ☐ CORRECTIONAL FACILITY (JAIL/PRISON)
- ☐ NURSING HOME
- ☐ VA HOSPITAL
- ☐ VETERAN'S HOME
- ☐ MILITARY BASE
- ☐ OTHER HOUSED (SPECIFY) _____
- ☐ REFUSED
- ☐ DON'T KNOW

D. EDUCATION AND EMPLOYMENT

1. Are you currently enrolled in school or a job training program?

[IF ENROLLED] Is that full time or part time?

- ☐ NOT ENROLLED
- ☐ ENROLLED, FULL TIME
- ☐ ENROLLED, PART TIME
- ☐ OTHER (SPECIFY) _____
- ☐ REFUSED
- ☐ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- ☐ LESS THAN 12TH GRADE
- ☐ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- ☐ VOC/TECH DIPLOMA
- ☐ SOME COLLEGE OR UNIVERSITY
- ☐ BACHELOR'S DEGREE (BA, BS)
- ☐ GRADUATE WORK/GRADUATE DEGREE
- ☐ REFUSED
- ☐ DON'T KNOW

3. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CONSUMER WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]*

- ☐ EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ☐ EMPLOYED PART TIME
- ☐ UNEMPLOYED, LOOKING FOR WORK
- ☐ UNEMPLOYED, DISABLED
- ☐ UNEMPLOYED, VOLUNTEER WORK
- ☐ UNEMPLOYED, RETIRED
- ☐ UNEMPLOYED, NOT LOOKING FOR WORK
- ☐ OTHER (SPECIFY) _____
- ☐ REFUSED
- ☐ DON'T KNOW

3a. *[IF EMPLOYED]*

- | | Yes | No | REFUSED | DON'T KNOW |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| • Are you paid at or above the minimum wage ¹ ? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Are your wages paid directly to you by your employer? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Could anyone have applied for this job? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

¹ For information on Federal minimum wage go to <http://www.dol.gov/dol/topic/wages/>.

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|_|_|_| TIMES

☐ REFUSED

☐ DON'T KNOW

F. PERCEPTION OF CARE

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED	NOT APPLICABLE
a. Staff here believe that I can grow, change and recover.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. I felt free to complain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. I was given information about my rights.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. Staff encouraged me to take responsibility for how I live my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
e. Staff told me what side effects to watch out for.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Staff respected my wishes about who is and who is not to be given information about my treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
g. Staff were sensitive to my cultural background (race, religion, language, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
h. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
i. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
j. I felt comfortable asking questions about my treatment and medication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
k. I, not staff, decided my treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
l. I like the services I received here.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
m. If I had other choices, I would still get services from this agency.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
n. I would recommend this agency to a friend or family member.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

F. PERCEPTION OF CARE (Continued)

2. *[INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE RESPONDENT FOR THIS INTERVIEW.]*

- ☐ ADMINISTRATIVE STAFF
- ☐ CARE COORDINATOR
- ☐ CASE MANAGER
- ☐ CLINICIAN PROVIDING DIRECT SERVICES
- ☐ CLINICIAN NOT PROVIDING SERVICES
- ☐ CONSUMER PEER
- ☐ DATA COLLECTOR
- ☐ EVALUATOR
- ☐ FAMILY ADVOCATE
- ☐ RESEARCH ASSISTANT STAFF
- ☐ SELF-ADMINISTERED
- ☐ OTHER (SPECIFY) _____

G. SOCIAL CONNECTEDNESS

1. Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	REFUSED
a. I am happy with the friendships I have.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I have people with whom I can do enjoyable things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I feel I belong in my community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. In a crisis, I would have the support I need from family or friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

H. PROGRAM SPECIFIC QUESTIONS (MAI-TCE)

Questions H1-H14
OMB No. 0930-0298
Expiration Date: 2/29/2016

Question H15
OMB No. 0930-0208
Expiration Date: 5/31/2015

3. Do you have health care coverage?

- ☐ Yes, government insurance
- ☐ Yes, private insurance
- ☐ No
- ☐ REFUSED
- ☐ DON'T KNOW

The following questions pertain to your attitudes and beliefs about alcohol, tobacco, and drugs.

4. How much do people risk harming themselves physically or in other ways when they smoke one or more packs of cigarettes per day?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk
- ☐ REFUSED
- ☐ DON'T KNOW

H. PROGRAM SPECIFIC QUESTIONS (MAI-TCE) (Continued)

5. How much do people risk harming themselves physically or in other ways when they smoke marijuana once or twice a week?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk
- ☐ REFUSED
- ☐ DON'T KNOW

6. How much do people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk
- ☐ REFUSED
- ☐ DON'T KNOW

The following questions pertain to your beliefs and attitudes about sex.

How much do people risk harming themselves physically...

7. if they have sex without a condom?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk
- ☐ REFUSED

8. if they have sex under the influence of alcohol?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk
- ☐ REFUSED

9. if they have sex while high on drugs?

- ☐ No risk
- ☐ Slight risk
- ☐ Moderate risk
- ☐ Great risk
- ☐ REFUSED

H. PROGRAM SPECIFIC QUESTIONS (MAI-TCE) (Continued)

HIV/AIDS and Substance Abuse Prevention

The following questions are to determine what you know about HIV/AIDS and substance abuse prevention.

10. Birth control pills protect women from getting the HIV/AIDS virus.

- ☐ True
- ☐ False
- ☐ REFUSED
- ☐ DON'T KNOW

11. There are drugs available to treat HIV that can lengthen the life of a person infected with the virus.

- ☐ True
- ☐ False
- ☐ REFUSED
- ☐ DON'T KNOW

12. There is no cure for AIDS.

- ☐ True
- ☐ False
- ☐ REFUSED
- ☐ DON'T KNOW

13. Would you know where to go in your community to see a health care professional regarding HIV/AIDS or sexually transmitted health issues?

- ☐ YES
- ☐ NO
- ☐ REFUSED

14. Would you know where to go in your community to see a health care professional regarding a drug or alcohol problem?

- ☐ YES
- ☐ NO
- ☐ REFUSED

H. PROGRAM SPECIFIC QUESTIONS (MAI-TCE) (Continued)**Recent Sexual Activity**

The following questions are regarding recent sexual activity.

15. During the past 30 days, did you engage in sexual activity?

- ☐ YES [*GO TO 15a.*]
- ☐ NO
- ☐ NOT PERMITTED TO ASK
- ☐ REFUSED
- ☐ DON'T KNOW

[IF THE RESPONSE TO 15 WAS “NO”, “NOT PERMITTED TO ASK”, “REFUSED”, OR “DON’T KNOW”, SKIP 15a, b, AND c.]

[IF YES] Altogether, how many...

	CONTACTS	REFUSED	DON'T KNOW
a. sexual contacts (vaginal, oral, or anal) did you have?	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
b. unprotected sexual contacts did you have?	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

[THE VALUE IN 15b CANNOT BE GREATER THAN THE VALUE IN 15a.]

[IF THE RESPONSE TO 15b IS 0, REFUSED, OR DON'T KNOW, SKIP 15c1-3.]

c. unprotected sexual contacts were with an individual who is or was:	CONTACTS	REFUSED	DON'T KNOW
1. HIV positive or has AIDS?	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
2. an injection drug user?	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
3. high on some substance?	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

[THE VALUE IN 15c1, 15c2, or 15c3 CANNOT BE GREATER THAN THE VALUE IN 15b.]

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

1. Have you or other grant staff had contact with the consumer within 90 days of the last encounter?

☐ Yes

☐ No

2. Is the consumer still receiving services from your project?

☐ Yes

☐ No

OMB No. 0930-0208
Expiration Date 05/31/2015

[IF THE INFORMATION BELOW IS UNKNOWN, RECORD "UNK" IN THE SPACE PROVIDED. IF THE SERVICE IS NOT AVAILABLE PLEASE ENTER "SNA" IN THE SPACE PROVIDED.]

1. On what date did the consumer last receive services? |__| |__| / |__| |__| |__| |__|
MONTH YEAR

	Sessions
9. Pharmacological Interventions	<input type="text"/> <input type="text"/> <input type="text"/>
10. HIV/AIDS Counseling	<input type="text"/> <input type="text"/> <input type="text"/>
11. Other Clinical Services (Specify)	<input type="text"/> <input type="text"/> <input type="text"/>

Modality	Days
1. Case Management	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Day Treatment	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Inpatient/Hospital (Other than Detox)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. Outpatient	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5. Outreach	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
6. Intensive Outpatient	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7. Methadone	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
8. Residential/Rehabilitation	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
9. Detoxification (Select only one)	
A. Hospital Inpatient	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
B. Free Standing Residential	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
C. Ambulatory Detoxification	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
10. After Care	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
11. Recovery Support	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
12. Other (Specify)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Case Management Services	Sessions
1. Family Services (Including Marriage Education, Parenting, Child Development Services)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Child Care	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Employment Service	
A. Pre-Employment	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
B. Employment Coaching	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. Individual Services	
Coordination	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5. Transportation	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
6. HIV/AIDS Service	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7. Supportive Transitional Drug-Free Housing Services	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
8. Other Case Management Services (Specify)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Identify the number of SESSIONS provided to the client during the client's course of treatment/recovery. [ENTER ZERO IF NO SERVICES PROVIDED.]

Medical Services	Sessions
1. Medical Care	_ _ _
2. Alcohol/Drug Testing	_ _ _
3. HIV/AIDS Medical Support & Testing	_ _ _
4. Other Medical Services (Specify) _____	_ _ _

Treatment Services	Sessions
1. Screening	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Referral to Treatment	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Assessment	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. Treatment/Recovery Planning	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5. Individual Counseling	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
6. Group Counseling	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7. Family/Marriage Counseling	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
8. Co-Occurring Treatment/ Recovery Services	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

After Care Services	Sessions
1. Continuing Care	<input type="text"/> <input type="text"/> <input type="text"/>
2. Relapse Prevention	<input type="text"/> <input type="text"/> <input type="text"/>
3. Recovery Coaching	<input type="text"/> <input type="text"/> <input type="text"/>
4. Self-Help and Support Groups	<input type="text"/> <input type="text"/> <input type="text"/>
5. Spiritual Support	<input type="text"/> <input type="text"/> <input type="text"/>
6. Other After Care Services (Specify)	<input type="text"/> <input type="text"/> <input type="text"/>

K. SERVICES RECEIVED (Continued)**Education Services**

- | | Sessions |
|------------------------------|-----------------|
| 1. Substance Abuse Education | _ _ _ |
| 2. HIV/AIDS Education | _ _ _ |
| 3. Other Education Services | |
| (Specify)_____ | _ _ _ |

Peer-To-Peer Recovery Support Services

- | | Sessions |
|---|-----------------|
| 1. Peer Coaching or Mentoring | _ _ _ |
| 2. Housing Support | _ _ _ |
| 3. Alcohol- and Drug-Free Social Activities | _ _ _ |
| 4. Information and Referral | _ _ _ |
| 5. Other Peer-To-Peer Recovery Support Services | |
| (Specify)_____ | _ _ _ |